

Insights on Rural Health Insurance Market Challenges from the National Advisory Committee on Rural Health and Human Services – 12/12/18

Kristine Sande: Good Afternoon everyone. I'm Kristine Sande, program director of the Rural Health Information Hub and I'd like to welcome you to today's webinar, "Insights on Rural Health Insurance Market Challenges from the National Advisory Committee on Rural Health and Human Services". And before we get started, I will quickly run through a few housekeeping items. We do hope to have time for your questions at the end of today's webinar. If you have questions for our presenters, we ask that you submit those at the end of the webinar using the Q & A section that will appear on the lower right hand corner of your screen following the presentations. We've provided a PDF copy of the presentation on the RHHub website, and that's accessible through the URL that's on your screen and we've also sent that link via the chat function, so you should be able to click on it there. For technical issues during today's webinar, we ask that you please call Webex support at 866-229-3239.

Our first speaker today is Paul Moore. He currently serves as the executive secretary for the National Advisory Committee on Rural Health and Human Services. He is also a senior health policy advisor to the Federal Office of Rural Health Policy. Paul brings a lifetime of experience related to rural healthcare from both his family heritage and more than 30 years in community and hospital pharmacy. His experience reaches beyond pharmacy as he has also been the CEO of a county healthcare authority, consisting of one of the nation's earliest critical access hospitals. The county CMF, a physician clinic and a home health agency. Paul is also a past president of the National Rural Health Association and with that, I'll turn it over to you, Paul.

Paul Moore: Thank you, Kristine. I'd like to take this opportunity to welcome our audience today to the webinar topic, "Insights on Rural Health Insurance Market Challenges by the National Advisory Committee on Rural Health and Human Services". In this webinar, we will provide an overview of the Committee, provide some background on the current landscape of the rural health insurance market, discuss relevant federal and state programs that relate to United States Department of Health and Human Services and review the Committee's recommendations for this issue.

First, I'd like to provide some brief background on the Committee. As a federally chartered independent citizen's panel, the Committee is tasked with advising the secretary of the Department of Health and Human Services on issues related to how the Department and its programs can better serve rural communities. The Committee is currently chaired by former Mississippi Governor, Ronnie Musgrove, and is comprised of 21 members. The experience and the expertise that the Committee members brings covers a wide variety of rural issues in fields such as Public Health, Medicine, Nursing, Human Services, Hospital Administration, Childcare, Research and Finance Law, and Business.

The Committee was formed in the late 1980's after a large number of rural hospitals closed. Since then, the Committee meets twice a year to examine pertinent issues that affect the health and well-being of rural Americans and to also hear directly from rural stakeholders in healthcare and human services. Following those meetings, the Committee produces policy briefs to the HHS secretary with recommendations on policy or regulatory matters, under the secretary's purview.

The last three topics that the Committee looked at and provided recommendations for were adverse childhood experiences, also known as ACES, suicide in rural America, and the

modernizing rural health clinic provisions. Those policy briefs along with others can be found on the Committee's website provided at the link on this slide. A quick online search of NACRHHS, will also bring you to the website. The most recent briefs will be located under the publications tab on the left of your screen. So why did the Committee choose to focus on this specific topic?

With many changes in the health insurance landscape over the past 10 years, and arguably over the last 20 to 30 years as well, the Committee felt a focused analysis of the current status of rural insurance markets was warranted for the betterment of rural health in the United States. Traditional fee for service models of insurance, such as original Medicare and some Medicaid programs, tend to pay for volume over value, thereby putting the payer and many times the federal or state governments at risk for high costs. The intent of using a managed care model for health insurance is to promote competition, control service use and ultimately lower costs. However, unique challenges in rural areas may actually inhibit competition, diminish coverage options and increase costs. The Committee wanted to explore the challenges to rural insurance markets which are often not accounted for in the way insurance markets are structured and considered recommendations to better support the use of managed care in rural areas.

With that background covered, I'd like to introduce our three speakers for the rest of this webinar. First, we will hear from a frequent collaborator with the Federal Office of Rural Health Policy, Dr. Abby Barker. Dr. Barker is a faculty lead for data and methods at the Center for Health Economics and Policy at Washington University in St. Louis Institute for Public Health. She is also a senior advisor for the Rural Policy Research Institute, you may know them as RUPRI. Her role includes helping social science and clinical researchers add cost and cost effective analysis to their work to increased policy relevance, as well as providing data visualization assistance to allow stakeholders to interact with the policy data.

Her current work for RUPRI focuses on understanding how markets can successfully be integrated into the healthcare sector. Using the Affordable Care Act, and Health Insurance Marketplace's data, as well as Medicare Advantage Data, to inform Rural Health Policy. Abby, we appreciate the work you've done for the Committee, for the Office, and in general to expand research for the rural populations in our country.

Dr. Barker will be followed by Normandy Brangan. Normandy is our go-to in the Office of Rural Health Policy, for any inquiries related to Health Insurance regulations and policies, particularly those related to the public insurance programs offered through CMS. Prior to joining the office, she was part of the CMS Innovations Center, Research and Evaluation group. In this position, Normandy managed contracts to evaluate the impact of a variety of policies on rural communities, such as the Rural Community Hospital Demonstration, the Rural Hospice Demonstration, and the Financial Alignment Initiative for dual-eligibles, Medicare and Medicaid enrollees. She is an invaluable resource in our office, and we're happy to have her on our team.

Our third speaker will be Kate Rolf. Kate is a current member of the National Advisory Committee on Rural Health and Human Services, who also served as a subcommittee chair on this topic during our April meeting in New York. She brings a wealth of knowledge in Rural Health administration to the Committee through her current position as President and CEO of Nascentia Health. Kate is leading the organization's turnaround and transformation efforts for over 600 employees and 1200 providers across the upstate New York region. Her leadership has led to a tremendous growth in the organization. Since she took the reins in 2011, Nascentia has increased its operated budget from 12.4 million to 250 million.

That created an inter-dependent, post-acute long term care health system that currently serves 48 counties and they doubled the number of direct care employees within the service area through consolidation with other home care organizations. Kate, thank you for your service to the Committee and for the work you do to provide needed health services to rural communities. Now that I've introduced our speakers, I will turn it over to Abby to provide some relevant background knowledge on the topic. Abby ...

Abigail Barker:

Good Afternoon, thanks for your participation in this webinar and I'm going to dive right in to my part of the presentation which is really focused on the economic analysis of this whole idea of taking a market mechanism, using it to allocate health insurance and how that does or doesn't work well in rural areas. So before I get really deep into the economic theory, which I am going to cover in a few slides, I just wanted to talk a little bit about the motivation for studying this topic, just by talking about some of the background in terms of what we've seen in the health insurance marketplaces over the last few years. And in the Medicare Advantage market and even in the Federal Employee's Health Benefits Program, so I'm going to be providing an economics based interpretation of these issues that arise when we're trying to implement market based insurance models in rural places.

I'm sure we're all aware of the many occasions on which the popular press and other institutions call attention to the fact that health insurance options are often lacking in rural counties. At various points in time, across various programs, there's a couple of headlines there on the slide to indicate that. On the next slide, I have a couple of maps, again calling attention to places in the United States where coverage options look like they were not going to be available. And mostly this is happening in rural counties. So on the left side, a map of Medicare Advantage, and the lack of participation in quite a few counties, mostly in the west and potentially no coverage in 2018.

Also, mostly in the west, also Alaska and then in the Affordable Care Act Exchanges, there was a lot of decline in participation for a number of reasons, but definitely focused on the fact that rural places were losing options was a predominate theme. In some places there was a risk of actually having no insurance whatsoever, and in many, many counties, there is only one option available to individuals who are wanting to participate in the ACA. In the next slide, I refer back to some older work that we have done with RUPRI, analyzing the FEHBP programs, the Federal Employees Health Benefits Program, which was the model, really for the ACA and has been in operation since 1965.

And just before I explain what you're seeing on the slides, I want to give you the background which is that there a handful of plans that are national. They're called nationwide plans and they offer coverage across the United States to any federal employee or annuitant. And there are also what's called state specific plans. And those plans have the option of offering coverage in a much more limited scope in terms of geography and they can choose their region at the county level. So that being said, the map that you see there illustrates the same issue of lack of coverage in rural places and shows that when plans do have the option, there's often avoidance of covering rural counties. And then importantly, I think, for this theme of using markets to bring about competition and hopefully better outcomes, lower prices and so on.

You notice that the table, that when you have a shortage or a lack of state specific plan options in a county, which is happening a lot in rural counties, then you really have an extraordinary amount of market dominance. You have 100% of people obviously have to be in a nationwide plan if there's no state specific offerings. And I just want to call your attention to the little arrow

that's showing between going from two to three state specific plan options, all the sudden there's a big jump in terms of market dominance and you go from 95% down to 65% of enrollment that is concentrated in one particular place. So moving along, I just want to talk a little bit real quickly about the changing cost distribution over time. Because I think this is important, it really underscores the rationale that private insurers have to really think hard about controlling costs.

As technological improvements over the last several decades have led to increasingly expensive treatments. Costs have been raised, particularly in the upper tail of the cost distribution, so costs are distributed in such a way that the tail is just dragging out longer and longer. I won't belabor the actual numbers there but just to say that the tail is being stretched and you have these outliers that cost millions and millions of dollars and that's a phenomenon that's become worse over the last 40 years.

Okay, now let me back up and talk a little bit about some economic theory that's going to be relevant to describing and analyzing what I think is going on in some of these rural health insurance markets. So the first problem is something that is an issue for all insurance markets. It's called adverse selection. And this is a situation in which healthier individuals choose not to purchase insurance at a given price, it's not worth it to them. Sicker individuals buy more comprehensive coverage, that's something we're probably all familiar with. And this basically shifts the composition of the risk pool. So you get more people who choose to buy insurance who are actually sicker, those people cost more money and this in turn drives the price up higher. It's kind of a snowball or spiraling effect.

Now before the Affordable Care Act was passed, in order to mitigate this kind of issue, firms had certain strategies that they would go to. Screening is one. Risk segmentation was a very popular one. And I think that's really relevant still today when we think about policy options because what risk segmentation does is it creates smaller submarkets that have different levels of risk. So that the insurance company can price each one separately. So it's sort of carving out the market into separate little submarkets to try to hone in on what the likely risk is for each one. I'll say more about that later.

Even within the market approach, there is potential for the government to place limits on firm's behavior, and so these are some of the policy options that can be debated. There can be direct regulations as well as other structures, things like bans on pre-existing conditions, bidding mechanisms, like we see in Medicare Advantage, subsidy design details, risk adjustment payments with all the different methodologies that are used to compensate insurers for the risk that they bear. Those are all additions meant to incentivize firms to participate in the market under the theory that many participating firms will, due to competition, lead to better outcomes. So obviously, the policy has always been about encouraging firms to participate. Because they think that competition is going to be advantageous overall.

Some evidence suggests that the market approach with this additional structure works reasonably well overall, across the board, for example on a MedPAC Report noted that in 2016, 81% of Medicare Advantage enrollees had access to a plan that charges zero additional premium beyond a Part B premium. So that sounds like a really robust finding. But in RUPRI analysis, a lot of times what we do is we take work that's already been done and we sort of re-do it with the urban and rural division to see how rural is impacted. And we found that that number is actually 83% of urban enrollees but only 47% of rural enrollees. And I think that's a great example of a situation where a policy is really structured with urban and suburban people

in mind. And it leads to really good outcomes in places where competition is robust and less good outcomes in other places that are more rural and I'm going to pick apart why that happens in the next few slides.

So getting into the rural specific issues, obviously the very first one is smaller populations and just stepping back and thinking about what modern health insurance is about. It's not just insurance, the way that you might buy insurance against fire or life insurance or any other form of insurance. It's actually intended to serve two functions, it is a mechanism for sharing risk, just like any other form of insurance would be, but it's also a means of access to a range of providers who help manage enrollee's health. So with respect to both of these functions, the current market based insurance programs fall short in rural areas for a couple of reasons.

The first one is in the sharing risk function. Because rural places by definition have smaller populations and lower population density, it's hard to share risk across many individuals. I'll say more about that in a moment. And then in terms of access to providers, rural places by definition have smaller populations again, so there are fewer healthcare providers of all types, and ensuring access is going to be more challenging. I've got a few statistics, probably familiar to most people in the audience about healthcare provider shortages there in the box. So delving in a little deeper, why are small risk pools problematic?

Each program, whether it be Medicare Advantage or Marketplace's or any program, the reimbursement formula does have a risk adjustment component. But the problem is that that's a very imperfect science. And even if you had access to a person's full claims history, you can still only predict about half of the variation in their future claims. So you can always figure out some way to adjust for risk after the fact. You can go in and compensate ex-post once you see how expensive claims were. But if you do that, then essentially the government is the true insurer, it's not actually the managed care company anymore, and that would increase their incentive to actually manage care and control claims, which is sort of what the government is attempting to pay them to do. So that's kind of the problem there.

And on the next slide, I apologize for how wordy it is. A different version of this unfolds one bullet at a time, so anyway, let me try to walk through why smaller risk pools are especially problematic. And this is really a mathematical argument. It's just that firms are relying upon the law of large numbers to forecast the number of claims, to some of the claims that they'll face. So in a large population, you can predict with a pretty good amount of accuracy, even the upper tail of that cost distribution, which I referred to on one of the earlier slides. That upper tail is getting more and more stretched with high outlier claims, way out on sort of the high end of the distribution.

So here's a couple of numbers to illustrate. In 2014, the top 1% of healthcare spenders had mean spending of about \$107,000 and that included a range of anywhere from \$75,000 to \$5 million. So if you have a population of 100,000 people in a risk pool, and statistically, you'll have about 1,000, that's the 1% who's been that average and you'll know that overall you're going to spend about \$107 million on that group of people. It's very unlikely, from a statistical view, that the sum will be very much different from that value. That's sort of how the statistics work in a large number population. But if you only have 1,000 people, for example, your 1% leaves you with about 10, who are way out there in the upper tail, spending between \$75,000 and \$5 million and with so few people, it's very uncertain where that average will end up.

If you have even two or three people who are closer to the 5 million, you can move the average quite a bit. And that's what makes it hard to price in the risk. In a large population, an insurance company can sort of hedge and they'll hedge and say, adding \$1 million to its revenues can be done by charging each person another \$10. So it's not really terribly difficult to do. But in a small population, that same hedging, would cost \$1,000 per person. So clearly you can't do that. No one would be able to afford the insurance and that's where the rub is. That's where it becomes very tricky.

And just as a parenthetical note, this is all taking place in an environment in which these insurance firms are pressured to show a positive return on investment every year, every quarter. So the reality of managing risk is that, if you're doing a good job managing risk, you're going to have some high's and some low's. Some negative as well as some positive performance over time, but because they're private companies, they are looking at trying to generate consistent positive profit every single quarter. So moving on then to talk about access and the role of insurance and providing access, I think that there are also challenges that are more pronounced in rural areas, again because of the low population density.

Many states have been proactive in defining what adequate access means. They create network adequacy standards and they measure and enforce those standards. And those standards mean that the health insurance company has to do the work and incur the administrative costs of forming networks of providers who can serve this diffused population. So providers are more likely to be independent or part of small practices, rather than part of any major system. And these administrative costs can be spread only over a small number of enrollees. The standards, combined with sparse providers in some rural places do create opportunities for strategic behavior by firms. I'll say a bit more about this in a minute.

The next big point I want to make here. This may even be the most critical point of all, is that I think there's some cost structure issues. Things that are different in rural places. Anecdotally, when a firm exists a rural place, sometimes they'll justify that by saying, "Oh, the rural providers there were too expensive, quote unquote. They weren't willing to come down on their price." And the reference point that they're thinking of is the negotiated rate that an urban provider is willing to accept. And so that's kind of what gives them that standard of saying something is too expensive.

In economics, it's a fundamental part of any cost analysis to distinguish fixed costs from variable costs and most people probably can understand what those differences are. Fixed costs are things like facilities, equipment, EMR systems. Variable costs are anything that vary by patient volume, so mainly additional staffing that you would need to see more patients. Fixed costs have to be incurred at a lump sum. And you try to recoup them by adding an amount equal to the average fixed cost onto the price of your services. A variable cost is flexible and so you can basically bill for that as part of the marginal cost of seeing a patient.

So you can see that in a rural place, that fixed cost issue is going to be a big concern. I think that the current market based models really encourage marginal thinking and what I mean by that is firms are assessing the costs of one more person against the benefit, the premium they can receive for enrolling that person and so when you think about the geographic area, that is the area that the program defines as sort of the minimum geographic area that a firm can locate in or can choose to offer coverage in. There's a big difference between having every single county being a marginal decision versus having a larger amount of counties grouped together or even a

state level area that a firm would decide, "Yes, I'm going into this state," or, "I'm not going into this state."

So Medicare Advantage benchmarks are actually different in every county and even though you might try to acknowledge the geographic variation by allowing the premium to vary. Firms are still going to want to keep their premium or their bid as low as possible and this creates an incentive to pressure rural providers to accept lower rates. And that's only if the provider is needed for network adequacy purposes, or they might just omit providers who cannot accept the lower rates, if that provider isn't needed for network adequacy. It's really creating an issue where insurers have this incentive to view each rural county as a reason that they may not necessarily find it worthwhile to enter, to compete in because of the fact that they may find that it isn't quite worth it in terms of the additional premiums that they collect, versus the work they have to do to comply with network adequacy standards and offer the full range of access.

A last couple of slides here, I think I'm taking up all my time and maybe then some. But a couple of real world impacts of what I've just been talking about, as I've mentioned a minute ago, the geographic unit for Medicare Advantage is the county. So the insurance company can decide for each and every county separately, "Do we want to be here?" And the firm's bid against a benchmark, that it's tied to prior data on how much fee for service Medicare is costing in that county. And it really encourages the firm to treat each county as a marginal decision. And because of that marginal decision, "Do we enter, do we stay, do we exit?"

Because the rural county is small and probably doesn't have all that much enrollment, they're balancing a fairly small amount of premiums collected against the fact that they have to have the network presence. The fact that the risk is there and it's uncertain whether they might have outliers in terms of high costs that will come up in that county. So that's the environment that they're deciding in. The geographic unit in health insurance marketplaces is different in different states. It's often a group of five or 10 counties or so and often includes a metropolitan or micropolitan area.

And state regulations vary quite a bit on whether the firm must offer coverage throughout the rating area. In some states it's okay to cherry pick portions of the rating area and then exclude a couple of counties on the edge if you can make the case that it's not possible for you to offer coverage there. So that just depends on the state. And again, the benefit then of larger rating area is that you're going to have a larger risk pool and that really helps with the issues that I spoke about at the beginning. The possible problem with a larger rating area though is the formation of a network that can actually cover the larger area. So there's tension between these two things.

The process of negotiating reimbursement rates ultimately depends on quite a few factors, including the market position of the insurance firm and the provider. And what I mean by that is who has market power. If the firm is accustomed to reimbursing marginal costs only, because they typically operate in urban and suburban areas, they may refuse to contract with a rural provider who needs those fixed costs to be covered. The bargaining power of the provider is weakened when they are heavily dependent on public dollar programs. So in a lot of rural areas where Medicare and Medicaid cover most of the bills, they don't have a lot of bargaining power when it comes to these kinds of negotiations. And bargaining power of the firm is strengthened by policies that limit their exposure if they fail to contract with the provider and that's a reference to the article snippet that is there at the bottom. That specific thing is happening.

Rural providers don't have the leverage because the plans are allowed to pay fee for service costs if one of their members comes to a non-affiliated hospital.

Alright, so just reaching the end of my section, in the real world, prices are negotiated for a continuum of different healthcare services of varying degrees of complexity. I think that's something that as an economist, I had to really come to appreciate and understand that it's not just healthcare, it's not just one monolithic good. It's a continuum and similar to other industries, this gives the larger providers, like larger hospital systems the incentive to pay strategically in order to undercut smaller local providers. And so that can happen where specifically you offer a marginal cost or even a below marginal cost price on services that smaller providers are able to provide. So you're competing with them on those services but then making up your own fixed cost on the complex services when there is no local competition there. So that's a real issue.

And that undercuts the local provider's ability to stay in the market. So you see local providers shutting their doors. And it also conveys to the insurer this sense that the local provider is too expensive to include in their network because they have this other information that suggests that they can get it cheaper somewhere else. Those are the issues I think that come about because we're attempting to use a model, this market based model, uniformly in urban, suburban and rural areas without really understanding that some of these aspects don't quite work in rural areas because of the low volume issues. So that's all I have.

Normandy Brangan: Thanks Abby, this is Normandy. And as Abby just laid out, there are numerous challenges setting up insurance markets in rural areas and Medicare, Medicaid and the individual health insurance marketplaces are relying more and more on the private sector managed care organizations to provide insurance coverage. A primary driver of this shift towards managed care has been to constrain federal and state costs. And more recently, the managed care model has also become a tool to coordinate and integrate care for enrollees. While federal and state governments use regulations and other policies to incentivize managed care organizations, to participate in the public programs, the level of federal and state oversight for each vary.

And the Committee had to take into consideration when developing the recommendation. So for example, HHS through CMS oversees Medicare Advantage and Part D prescription drug programs but CMS alone determines the payments to the plans and they review and approve the plan offerings, establishes the network adequacy standards, and monitors the quality and access to care. Medicaid, which provides coverage for eligible low income and individuals with disabilities, is a joint federal and state program. And states fund and administer and conduct the day to day operations for Medicaid and CMS provides funding, oversight, technical assistance.

So it's the states that are choosing whether and to what extent to use managed care to provide coverage but they have to first submit waiver applications or state plan amendments to CMS for approval. And then once it's approved, the states select the managed care organizations to operate the service areas and the network adequacy standards. CMS then will issue rules and regulations that implement statutory requirements, monitor quality and access for enrollees and strengthen program integrity. So for the health insurance marketplaces, CMS oversees and operates [healthcare.gov](https://www.healthcare.gov), the online platform that we've heard so much about. Where consumers can purchase insurance coverage, but there are states that run their own exchanges at different websites.

Sorry, I will try to talk louder without yelling. And CMS develops the policies and regulations to oversee how the states and the insurers implement the exchanges. But you have the state insurance departments have flexibility to oversee the market. It's the states that determine the ratings areas that Abby was referring to and they can specify whether plans must be offered throughout the rating area. And the states also develop and enforce the network adequacy standards. CMS, on the other hand determines the methods for calculating risk adjustment for the insurers, monitor the quality ratings of plans and provide premium support to consumers with lower incomes.

So clearly, states play a large role in the policies and regulations regarding Medicaid and the health insurance marketplaces but there are opportunities for the federal government to address the role market challenges that crosscut Medicare, Medicaid and the marketplaces. So with that context in mind, I'll hand it off to Kate to discuss the Committee's final recommendations.

M. Kate Rolf:

Thank you Paul and Abby and Normandy for setting the stage for the Committee's recommendations on this topic. Before I dive in to the final recommendations of the Committee, I'd like to provide some feedback from the stakeholders. On the first day of our meeting, state level officials from the state level officials from New York State Department of Health and the New York State Department of Financial Services provided the context of the current policies affecting rural New Yorkers. When speaking with the officials, it was clear that New York chose a strong regulatory approach to setting up its markets, building on its experience with Medicaid, managed care.

This approach has led to their insurance markets having insurance providers, often multiple in every county. And during the second day of the meeting, the subcommittee on Rural Health Insurance Markets traveled to Glens Falls, New York with the Adirondack Health Institute graciously hosting our meeting that day. So when we visited Glens Falls, New York, it's a city approximately 14,000 people located in east central portion of New York State, where the Hudson River flows north of the top of the city's border. At the Glens Falls site, the Committee interacted with several interested local stakeholders, including Adirondack Health, Chautauqua County Health Network, Citizen's Advocate, the Franklin County Office for the Aging, Glens Falls hospitals and United Helpers.

Considering the broad and complex nature of the topic, the Committee chose to group the recommendations around three specific issues. The availability of insurance, network development and adequacy and consumer and provider engagement. The genesis of these themes occurred as a result of the stakeholders input from sites visit. To ensure the accessibility and the availability of insurance in rural markets, the Committee believes there must be a way to expand the risk pool and expand access to providers in rural networks. Additionally, given the higher rates of poverty and uninsured in rural areas, the Committee believes it would be beneficial to have processes in place to help minimize turn between insurance programs.

Therefore, the Committee believes these recommendations to be the most immediate route to address those issues. One, is the Committee recommends a secretary require the alignment of insurance plan service areas with ratings areas for insurance programs under HHS authority, utilizing models that integrate urban and rural areas in a region to increase risk size and under this model, the Committee recommends requiring full participation across the rating service area rather than allowing insurers to offer products to only a portion of the rating area.

And the second recommendation the Committee recommends to the secretary that they require states that have processes in place to streamline the transition from Medicaid to the individual market or vice versa, reducing the turn between the two. And minimizing lapses in insurance coverage. For network adequacy and development, given the difficulty of forming networks to rural providers, the Committee believes that strategic flexibility and network adequacy requirements such as when provider or plan shortages exist. They encourage full insurer participation across rating areas.

Additionally, since rural providers are at risk of being undercut by larger providers, during the negotiation process, the Committee believes that providing technical assistance to providers specifically related to their contact negotiations with insurers will be beneficial in improving provider participation in the networks. With consumer and provider engagement suggestions, the Committee believes improving rural consumer engagement could lead to increased enrollment in insurance markets, thereby increasing the risk pool. Educating both consumers and providers on a variety of plans available, for example, Medicaid and Medicare may offer multiple plans in an area. That is a useful step to improving participation and engagement and creating a better functioning rural insurance market.

So, in conclusion, the Committee did want to make mention of the fact that when we spoke to the state officials and local providers in New York, it's very apparent that New York has a very strong regulatory approach to setting up its markets, building on this experience in Medicaid and managed care. This approach has led to New York's insurance market having insurance providers and often multiple and every single county. At the same time, we realize that each state is different and may prefer more flexibility in its regulatory approach to insurance market. We do hope that policy makers think more proactively about the unique challenges faced by the rural markets and account for them when setting in regulation policies. So with that, I'd like to turn it back over to Paul.

Paul Moore: Thanks Kate. Let's see if we can get it to the next slide. We appreciate your presentation on these recommendations on behalf of the Committee and for your work as a subcommittee chair for this topic. We know the great efforts that you went to and we greatly appreciate it. Before we move into the question and answer session, please remember to visit the Committee's website at the link on this slide, after this webinar to learn more about the Committee and to read up on the Committee's previous work. And now I'll turn it back over to Kristine for our question and answer period. Kristine ...

Kristine Sande: Thanks so much. Those were great presentations. And hopefully everyone learned a lot and got a sense of what the Committee is recommending. So at this point we have opened it up for your questions and ... A Q & A session. You should be able to see the Q & A box down at the lower right hand corner of your screen. So that's where you can enter any questions that you might have for our presenters. We'll give it just a few seconds here to hopefully get some questions from folks. Alright, looks like we do have a question. The question is, "In recommending that we relax network adequacy standards in hopes that more plans could be offered in rural areas, don't we run the risk of more plans offered in rural counties that do not include the rural providers as in network?" Would someone like to take that question?

Paul Moore: Kristine, I'll field that and then invite any of my colleagues that want to join on that. As you watched the presentation, we got the economist view of why the insurers are doing what they are doing. The question does make a lot of sense. There's a pressure on that negotiating and there is the concern that if network standards are lessened, that means rural providers may be

left out and patients may not be able to use their rural providers. It is an issue with multiple perspectives to it and a working back and forth between the balance of providing those coverages for those needs in those rural communities. Does anyone else have something they would like to add to that?

M. Kate Rolf:

This is Kate. From our perspective at the Committee level, we did bounce that around and talk about that a bit, so it is a doubled edged sword. Obviously the ability to have more plans in an area does require network adequacy and often it is only the rural providers available, so if plans are unable to negotiate with those rural providers it makes it very difficult. The thought behind it was in hopes that ... In making the relaxed regulations that there could be potentially some requirement of including any rural providers in addition to others in the surrounding community because we understand you don't want to have the local provider's rates ratcheted down or being forced to ratcheted down when it's not financially feasible.

Abigail Barker:

If I could add to that, I think, I mean this is just my personal policy recommendation, not part of the Committee, but I would probably say that you don't want to relax network adequacy standards in isolation, necessarily. One really important tool, which I do think was mentioned, on the slides, is to find ways to really increase consumer engagement and transparency. So that you're telling people, as they're signing up for certain plans, exactly what their network is going to be if they pick option A, versus B, versus C, so that you can let people know and people and their consumers can signal to the insurance companies what they do value and how far they want to travel and whether or not they value having a local rural provider.

If they know that they're signing up for something that doesn't include a certain provider that's close to them, that's a totally different thing from having all of that information obscured and just signing up for something because it is sorted to the top of the some online shopping page. So that's one thing I would say and then also just to the point of the fixed costs and variable costs that I talked about. I mean I would also think that some form of shifting of policy to address some of those fixed costs for rural providers would just help them be a lot more competitive so that they wouldn't have to drop out in the negotiation process in a situation like this if standards were relaxed.

Kristine Sande:

Alright, well thank you for those comments on that. One other question. "Please review the next steps following these recommendations from the Committee, so what happens next?" Paul, do you want to take that question?

Paul Moore:

Certainly, I appreciate that question. These recommendations are passed to the secretary of Health and Human Services and the secretary then also will take them to the departments. In this case it may be CMS or other departments with other briefs, and while the Committee can put those recommendations forth, they are just that, recommendations. Which can be acted upon, can be ignored, or can be taken very seriously.

And so our next step as far as the Committee, is to put those recommendations forward with the case for them as seen by the Committee but then also to monitor. We do monitor what actions are taken and from time to time even go back years to see where the Committee's recommendations have been acted upon. We do keep it within our purview ... We try to stay within the Committee within the purview of HHS, sometimes things may take legislative action in that case, hopefully the news is out there but that is not the focus of the Committee.

Kristine Sande: Alright, the next question is, "I'm interested in whether the Committee has considered requiring more transparency and accountability of insurance providers. Dealing with these organizations requires considerable resources to chase payments and answers to necessary questions." Any thoughts on that.

M. Kate Rolf: This is Kate.

Paul Moore: I will...Please.

M. Kate Rolf: Sure. We didn't really deal much with this issue. That was not a topic that came up during our meeting from that approach. We didn't get that side from any of the providers that we had met with. So unfortunately, no, we didn't really address that at the time of the meeting.

Kristine Sande: Alright, another question is, "What about an alternative payment model for hard to serve rural areas? Maybe a demonstration project? Is there any discussion along that lines?"

Paul Moore: Thank you. I will say the Committee has done work on alternative payment models, alternative delivery system models in a previous work. I invite you to go to the website and access that policy brief and the recommendations that went to that. The Committee is not just stopping on what we have done though. We're also making the point, that we're watching closely as alternative payment models and even demonstrations take place in rural areas. We advocate for more rural specific demonstrations around both delivery system and alternative payment models. So it's a past work of the Committee and I'm sure at some point we'll be a future work of the Committee because we remain very interested in that.

Kristine Sande: Alright, well I don't see any additional questions at this time, so I think we will bring our webinar to a close. I'd like to thank the folks that have joined us from the National Advisory Committee on Rural Health and Human Services for all the great information that they shared with us today. And I'd also like to thank all of our participants for joining us as well. A survey will automatically open at the end of today's webinar and we encourage you to complete the survey to provide us with feedback that we can use when hosting future webinars. The slides used in today's webinar are currently available at the link listed on the slide.

In addition, a recording and a transcript of today's webinar will be sent to you by email in the near future so that you can listen again or share the presentation with your colleagues. Thank you for joining us and have a great day.